TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Liberty Mutual Insurance Co

MFDR Tracking Number
M4-17-0602-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After reviewing the account we have concluded that reimbursement that reimbursement received was inaccurate."

Amount in Dispute: $1,311.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Reimbursement for physical therapy procedure codes were calculated using the medical fee guidelines "in effect for that service."

Response submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2016 through June 24, 2016	Outpatient physical therapy services	$1,311.98	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.403 sets out reimbursement guidelines for services provided in an outpatient setting.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 – the charge for this procedure exceeds the fee schedule allowance

- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- ESIE – According to CMS rules status indicator E codes are not payable on OPPS
- B13 – The charge for this procedure exceeds the fee schedule allowance
- W3 – The charge for this procedure exceeds the fee schedule
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

Issues

1. Is the carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services is dispute are physical therapy services provided in an outpatient setting.

   The requestor is seeking an additional payment of $1,311.98. The carrier made a payment of $928.39 for these dates of service. The payments were reduced with remark codes Z710 – "The charge for this procedure exceeds the fee schedule allowance."

   The maximum allowable reimbursement is calculated below.

2. Review of the submitted medical claims finds the "type of bill" is "131" or Outpatient Hospital. Therefore, these services are subject to provisions of 28 Texas Administrative Code 134.403(d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…

   The applicable Medicare payment policy can be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resource that define the components used to calculate the Medicare payment for OPPS are found below:

   – **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

   Review of Addendum B applicable to the June 2 - 24, 2016 dates of service finds the following:

   - Procedure codes 97110, 97140, 97112 and 97116 have a status indicator of A denoting services paid under a payment system or fee schedule other than OPPS.

   Per 28 Texas Administrative Code §134.403(h),

   > for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided.

   Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, 28 Texas Administrative Code §134.203(c) which states in pertinent part,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)

Per 28 Texas Administrative Code §134.403 (b)

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Per Medicare Claims Processing Manual found at www.cms.gov, in section, 10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

The calculation of the maximum allowable reimbursement as described above is as follows:

- Procedure code 97112, service date June 2, 2016. Billed units (2). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $51.59. The PE reduced rate is $39.05. The total is $90.64.
- Procedure code 97110, service date June 2, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $38.00.
- Procedure code 97116, service date June 2, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $33.39.
- Procedure code 97110, service date June 3, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $38.00.
- Procedure code 97112, service date June 3, 2016. Billed units (2). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $51.59. The PE reduced rate is $39.05. The total is $90.64.
- Procedure code 97116, service date June 3, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $33.39.

- Procedure code 97140, service date June 8, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $35.35.
- Procedure code 97110, service date June 8, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $38.00.
- Procedure code 97112, service date June 8, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $51.59.
- Procedure code 97116, service date June 10, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $33.39.
- Procedure code 97112, service date June 10, 2016. Billed units (2). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $51.59. The PE reduced rate is $39.05. The total is $90.64.
- Procedure code 97110, service date June 10, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $38.00.
- Procedure code 97140, service date June 24, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $35.35 at 2 units is $70.70.
- Procedure code 97112, service date June 24, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $51.59.
- Procedure code 97110, service date June 24, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $38.00.
- Procedure code G8978, service date June 24, 2016, has status indicator Q, denoting a therapy functional information code (used for required reporting purposes only). Reimbursement not allowed.
- Procedure code G8979, service date June 24, 2016, has status indicator Q, denoting a therapy functional information code (used for required reporting purposes only). Reimbursement not allowed.

3. The total allowable reimbursement for the services in dispute is $771.32. This amount less the amount previously paid by the insurance carrier of $928.39 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 30, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.